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REPORT FROM THE TASK FORCE

ON

LODGING HOMES

URBAN [illegible]STION CENTRE
RESEARCH [illegible] STUDIES
MCMASTER UNIVERSITY
HAMILTON, ONTARIO

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THE SOCIAL PLANNING and RESEARCH COUNCIL of Hamilton and District

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PREAMBLE

The Task Force would like to briefly outline the impressions it had of the milieu in which its deliberations occurred. The striking of the Task Force by the Social Planning and Research Council was not the result of a perceived crisis in the supply of residential alternatives as it relates to lodging homes (that is, in the number of beds). Hamilton has, to the best of our determination, a sufficient number of beds available in lodging homes.

The Task Force, in fact, was the result of a fairly lengthy process originally initiated by contract lodging home owners and operators themselves.

Hamilton has, over the past few years, made progressive decisions with regard to lodging homes. The adoption by Council of Hamilton's Second Level Licensing By-law during the life of the Task Force bears mute witness to this fact.

At the same time, it would be irresponsible to suggest that the situation of lodging homes within a continuum of housing and care alternatives does not have its problems. The focus of this report will demonstrate that there is still lots of room for improvement, particularly along the dimension of the availability of housing alternatives which provide a wide range of levels of care suitable to the needs of residents. The beds may be there, but the Task Force is concerned that those beds be made as appropriate as possible.

The Task Force believes that the recommendations contained in its report will go some distance in addressing this problem of appropriate alternatives, and hopes they will be seen as a means to improving and strengthening the continuum of care available to special needs clients in our community.

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INTRODUCTION

The Task Force on Lodging Homes was formed by the Social Planning and Research Council (SPRC) in August, 1980 in order to:

1) Review the present quality of care arrangements in Contract Lodging Homes;
2) Review existing studies for developing differential standards;
3) Recommend adequate per diem rates for contract lodging homes.

This mandate was developed from the results of a preliminary survey of contract lodging homes conducted in the Spring of 1980 (see Progress Report: Lodging Homes Evaluation) by the SPRC at the request of contract lodging home operators. While the initial request from operators asked for concrete recommendations for a new per diem rate from the Region of Hamilton-Wentworth, the SPRC survey concluded that:

> Unfortunately, the accounting practices of a number of the lodging homes were not sophisticated enough to be utilized as a basis for calculating optimal per diems.

Other methodologies, including consultation with "experts", also resulted in insufficiently confident estimates of appropriate per diem rates. The Progress Report, therefore, concluded that:

> ...the per diem rate to lodging homes under contract to Regional Social Services needs a re-examination as to the adequacy of present per diems. This re-examination should take place in conjunction with a review of the quality of service offered by homes. It is possible that a more flexible funding procedure could be justified which would take into account different levels of care.

The Task Force was mandated to undertake such a review and included representatives from the Ministry of Community and Social Services and Regional Social Services (in the capacity of consultants),

Assessment and Placement Services, the psychiatric network, Mental Health, the General Hospital, the District Health Council (Group B), and the SPRC, as well as operators of contract lodging homes.

It is our hope that the deliberations of the Task Force which have resulted in the recommendations contained in this report will lead not only to improvements in the quality of life for special needs residents in local lodging homes, but also to a commitment from agencies and individuals working with special needs clients to a systematic and ongoing evaluation of the range of options available for ensuring that the potential of community-based care is realized.

THE CONTRACT LODGING HOME

Of the approximate 100 lodging homes in the City of Hamilton, 27 have entered into an agreement with the Region as hostels under the General Welfare Act. Under this agreement (See Appendix A, "Operators Standards for Lodging/Boarding Facilities"), operators accept a greater degree of responsibility for their residents than do the operators of ordinary lodging homes (for example, there must be 24 hour a day supervision, monitoring of the consumption of each resident's medication, et cetera). Operators entering into such an agreement operate what are commonly referred to as contract lodging homes.

On April 1, 1981, a new licensing by-law which recognizes a second-level lodging home came into effect in Hamilton, legally codifying certain aspects of supervision, medications and building, fire and safety regulations. The by-law's definition of second-level lodging homes clearly suggests that the licensing of second-level lodging homes and the contract between lodging homes and Regional Social Services have parallel intents.

(25) "Second Level Lodging House" means a House:

i) which accommodates four or more Residents;

ii) where, for a fee, the Operator offers to Residents guidance in the activities of daily living, and advice and information;

iii) where, 24 hours a day, at least the Operator or one adult employee of the Operator, is on duty in the House and able to furnish such guidance.

(1) activities of daily living mean those activities of the individual that maintain his sufficient nutrition, hygiene, warmth and rest.

(By-Law No. 80-259 (81-93), City of Hamilton)

This parallel intent has been formalized by Regional Social Services through the understanding that, with the establishment of the By-law, all lodging homes operating under a contract with the Region will have to meet the requirements of the second-level licensing By-law (with some flexibility in application due to the problems associated with retroactivity).

In return for providing a higher level of care than that available in ordinary lodging homes, operators in contract homes receive a per diem ($10.50 in 1979, $11.40 in 1980 and $14.00 in 1981, retroactive to January, after an appeal was made to the Regional Social Services Committee). Running their homes as independent businesses, operators complain that the current per diem is inadequate to meet rising costs, and that changes which will have to be made in order to comply with the new By-law will be very costly, adding further expense, and, consequently, potential strength to the argument that the current per diem is insufficient.

THE SPECIAL NEEDS CLIENT

The SPRC survey of contract lodging houses indicated that most of the residents (see Table 1) in contract homes were either categorized as psychiatric* or elderly (although it should be pointed out that these are not necessarily mutually exclusive categories). Of equal interest is the fact that 88.6% of the residents' incomes were from government transfer payments (disability pensions, general welfare and old age pensions), and residents tend, therefore, to be at the lower end of the socio-economic scale.

In sum, the survey concluded that contract homes tend to serve the poor components of the psychiatric and elderly populations who do not have the financial resources for independent living.

Residents of contract homes may, however, vary in their needs along many dimensions. The existence of 24 hour supervision may tend to obscure the fact that this supervision, when provided in a programmatic fashion, could meet varying client needs ranging from maintenance to certain types of rehabilitation.** As discussed below, the Task Force has strong concerns that this potential is not being met.

The Task Force recognizes that while elderly and psychiatric residents currently constitute the majority of "Special Needs Clients", it also recognizes that the composition of this population may change over time. Recommendations made in this report reflect this possible change in the future composition of the "Special Needs Client" population.

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* The term "psychiatric" used here means a person who has been or is involved actively as a client in the psychiatric network but who is not currently institutionalized. It is used in preference to ex-psychiatric because it implies an ongoing need for involvement with the psychiatric network.

** The Task Force is using the term "rehabilitation" within a generic context.

TABLE 1

CHARACTERISTICS OF
RESIDENTS IN CONTRACT LODGING HOMES
N=373*

Status of Residents		
Psychiatric patients	-	54.0%
Senior citizens	-	29.6%
Disabled	-	1.0%
Mentally Retarded	-	4.4%
Alcoholics	-	6.6%
Other	-	4.4%
Age		
Less than 20	-	1.9%
20-35	-	24.2%
36-50	-	24.2%
51-65	-	22.9%
Over 65	-	26.7%
Source of Income		
Disability Pension	-	37.6%
General Welfare Assistance	-	26.2%
Old Age Pension	-	24.8%
Personal Resources	-	11.4%

* Only about 270 of this population were subsidized by the Region.

THE REALITY OF DE INSTITUTIONALIZATION

The needs of clients and residents, as well as the place of contract homes within the community-based adult residential care network, should be viewed within the larger context of shifting emphasis in policy from the various concerned provincial ministries and local agencies.

The Ministry of Community and Social Services is, currently, involved in the issues around contract homes through a combination of its income maintenance programmes (which in many cases form the only income of contract home residents), through community support services which it funds, and through the cost-shared funding of per diems paid to contract homes.

The Ministry of Health is involved in the issues through the provision of selective support programmes (such as Community Social and Vocational Rehabilitation (CSVR), and through their involvement (through the hospital system) with any residents who may have been placed in contract homes by health-funded authorities (the Hamilton Psychiatric Hospital or the general hospitals, for example). These Ministry involvements, however, tend to be at the level of interface and interaction locally and in no way reflect conscious policy decisions on the part of the Provincial government. In fact, contract homes, in this sense, become sterling examples of a process of de-institutionalization which has occurred with neither policy articulation or funding rationalization.

1. The Case of Psychiatric Facilities

The best example of this process at work can be found in the recent history of growth and funding of psychiatric facilities and community-based programmes. During the 1960's and continuing today, the in-patient population of psychiatric facilities in Ontario dropped dramatically. Psychiatric beds in Ontario have

been reduced almost 75% from 16,000 to 4,600 between 1963 and 1978. (Ontario Welfare Council, Perspectives on Community Based Services: The Case of Adult Residential Facilities). Available beds at the Hamilton Psychiatric Hospital (HPH) dropped from 1,730 in 1960 to 525 in 1977 (Mental Health/Hamilton, Coping in the Community). The drop in the number of beds has, however, been paralleled by a growth in the total number of short-term admissions/discharges to and from psychiatric facilities. The implication is that many of these discharges from psychiatric facilities are of necessity being made into the community. Existing studies would indicate that as many as 20% of discharges might be self-referrals* and that this "seems to be the group at greatest risk in the community". (Mental Health/Hamilton)

The Mental Health/Hamilton study (reviewing a period of one year, 1978-1979) found that 86.2% of discharges from HPH were to family or were self-referrals (418 of 485). If we assume that up to 20% might have been self-referrals (as suggested by other studies), approximately 97 patients would have been discharged - on their own - into the community. This is, of course, supported by the fact that psychiatric patients make up such a large part of the contract home resident population.

The last decade or so has, then, been characterized by de-institutionalization in practice, with increasing numbers of patients having short-term stays in psychiatric facilities before being returned to the community. However, this process has been lacking in planned, co-ordinated support to the community as patients are returning:-

* Self-referrals, as used in the Mental Health/Hamilton study, mean clients referred into the community on their own i.e. not into their families or other organized institutional facilities.

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> At the moment, the funding of community-based residential alternatives to institutional care for the mentally ill appears to be a low priority.
>
> (Metropolitan Toronto Social Services and Housing Sub-Committee on Boarding Homes and Lodging Houses, Final Report: Adult Residential Facilities, p.13)

The Task Force believes that trying to argue the "cost benefits" side of de-institutionalization is inappropriate in this context (whether, indeed, such an argument can even be made). The leading professional assessments of the psychological and emotional benefits which may accrue from living in the community (as opposed to institutional care) are, we feel, of more fundamental importance.

However, in order to ensure these benefits do, indeed, accrue, it is necessary to ensure that resources appropriate to this goal are made available. In the case of contract homes, we feel that, what supportive assistance has been available to the resident in the community has been due to the individual initiative of workers and, in some cases, individual contract homeowners. The government role in this process has been that of under-funding and lack of planning. If, indeed, our community is to provide adequate care for residents, this situation must change.

In the Legislative Assembly of Ontario on October 18, 1979, the then Minister of Community and Social Services, Mr. Keith Norton, expressed his government's commitment to the policy of de-institutionalization:

> "....the government for some time has supported a policy and has been embarked upon a policy of assisting individuals in provincial institutions to be reintegrated into the life of their community, and it has encouraged the development of support services in the community to assist them."

The government has argued that increased spending and programme development in the area of community support services bears witness to this commitment. Many have argued that these increases and programme developments are insufficient.

With regard to lodging homes in particular, there has been a failure on the part of government to acknowledge the potential role of lodging homes along a continuum of care, and a failure to recognize that many residents of lodging homes are, in fact, special needs clients.

In the same debate in the Legislature, Mr. Timbrell, Minister of Health, argued that:-

> "I think it is quite unreasonable to suggest...that a person has been discharged from a psychiatric facility...they should, in effect, be kept institutionalized by keeping them on some kind of a roster, in effect keeping them under supervision .... I draw a distinction between a person who is in need of continuing care - and I do not for a moment deny we have a responsibility to the homes-for-special-care program and the approved home program...or within the psychiatric facility... But once a person is discharged, they are free to come and go as you or I, Mr. Speaker."

This perception on the part of government denies that many residents (particularly in Hamilton, many of those in contract homes) in lodging homes are, in fact, special needs clients requiring minimally "supervision of the activities of daily living", and as the Task Force will argue, programming.

The Task Force believes, therefore, that there must be a new government commitment to this population expressed through the funding and development of resources and programmes as part of a larger plan for de-institutionalization.

2. The Case of the Elderly

Contract homes provide an equally important residential alternative for some elderly people. Placement decisions may be made by a wide variety of persons, including hospital social workers, families or, in some cases, the individual themselves.

However, the elderly living in contract homes who are subsidized by the Region do share two essential characteristics with the psychiatric population:

a) they require supervision of the activities of daily living;

b) they have limited incomes.

Moreover, it is to the Province's financial advantage for a client to be placed in a contract home as opposed to a nursing home, Home for the Aged, or other institutions. The Task Force is, therefore, concerned that adequate funding be made available.

THE CONTRACT HOME: WHAT DOES IT PROVIDE?

The Task Force spent some time in attempting to determine the actual day-to-day role of the contract home, and it became clear in its discussions that variability was the outstanding feature from home-to-home.

The Task Force feels that the new second-level licensing By-law adequately deals with the health, safety, fire, hygiene and nutritional needs of residents as long as these standards are effectively enforced. Therefore, we would recommend:

#1 THAT THE SOCIAL PLANNING AND RESEARCH COUNCIL DETERMINE WHETHER OR NOT SUFFICIENT RESOURCES HAVE BEEN ALLOCATED TO ENSURE EFFECTIVE ON-GOING ENFORCEMENT OF BY-LAW NO. 80-259 (81-93).

The Task Force, however, identified three major areas which exhibited great variability from contract home to contract home and which it feels are either not adequately dealt with by the By-law or which fall outside the legal scope of the By-law.

1. Staffing

a) Staff to Client Ratio

Current contract homes are required to have at least one adult staff on the premises at all times. Any additional staff is at the discretion of the operator.

b) Training

Operators of contract homes must have a Grade 12 education and employees a Grade 10 - if educational requirements cannot be met, then employees must produce evidence of sufficient similar work experience. At present, there are no planned training programmes for operators and employees (e.g. safety, nutrition, first aid, et cetera) and training is entirely at the individual operator's discretion.

2. Programming

There is no planned or standardized programming in lodging homes except in individual cases where an operator may programme independently. Failure to programme is not a fault of the operators, but, rather, may be a function of:

a) low staff/client ratio;

b) poor links between contract homes and referring agencies;

c) clients not encouraged to grow because then operators lose clients;

d) operators/staff not trained to provide programmes;

e) poor matching of client populations;

f) poorly planned and funded community services to meet programming needs;

g) service network may be too dependent on operators to define client needs;

h) failure heretofore to define whose responsibility programming is or should be.

Current care in contract homes can best be styled as custodial, and the Task Force clearly recognizes the problem this presents from a programming point of view when residents may actually need a rehabilitation component in their care.

3. Client Participation

There is no planned effort to match client needs with accommodations and, therefore, there is no mechanism to indicate the appropriate or necessary therapeutic level of client participation, whether in choice of home, the opportunity to learn life skills, et cetera.

Each of these areas is important if, in fact, one of the goals of placement or referral to a contract home is good supervision of the activities of daily living - in other words, a good quality of care.

CONTRACT HOMES: WHAT IS EXPECTED OF THEM?

Since a large proportion of contract home residents are referred by professionals, the expectations of professionals as to what a contract home provides carries some weight in considering quality of care arrangements.

Professionals sitting on the Task Force, after some discussion, determined that their referred clients tended to share the following characteristics:

Psychiatric Clients:

a) they are deemed not a danger to themselves or others.
b) they are unable to self-administer medications.
c) they require varying levels of supervision of the activities of daily living.
d) most do not have physical handicaps.

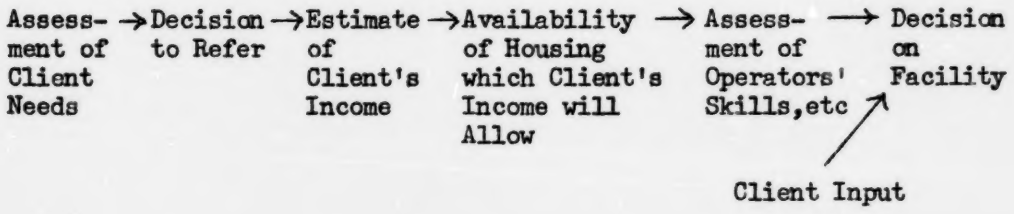
The Elderly:

a) they are deemed "at risk" by someone.
b) they may be on waiting lists for more appropriate placements.
c) they require varying levels of supervision of the activities of daily living.

Despite shared characteristics of some clients, professionals stressed that decisions about referral may be quite arbitrary, depending on subjective personal assessment of the operator and his/her personal attributes. There is, in fact, a lack of clear criteria for placement into lodging homes, and variability in staffing, programming and levels of client participation from contract home to contract home minimizes the opportunity for the development of clear criteria.

Figure 1 represents the decision-making process which professionals indicated typifies their own experience.

FIGURE 1


Assessment of Client Needs
Decision to Refer
Estimate of Client's Income
Availability of Housing which Client's Income will Allow
Assessment of Operators' Skills, etc
Decision on Facility
Client Input

In this process, the critical decision points are the assessment of client needs, availability of housing which falls within client's income constraints, and professional assessment of the operators' skills. Client input becomes important in the pre-determined set of contract home alternatives presented to the client by the professional.

Professionals were quick to point out that each of these key decision points could be arbitrary in the extreme: lack of clear criteria for assessing client needs in terms of appropriate placement causes variability; income plays a heavily weighted role in the process of referral; and, professional assessment of operators' skills may be arbitrary, highly personalized, and vary from professional to professional.

What this suggests is that referring agencies and individuals may be as equally variable in their referral process as contract homes are in the areas of staffing, programming and level of client participation.

CONTRACT HOMES: THE CLIENT PERSPECTIVE

We have already seen that client involvement in the referral process may be variable and often times minimal. However, the Task Force felt it was also important to gain some insight into residents' perceptions of the quality of contract homes.

The Mental Health/Hamilton study previously cited included a survey of psychiatric clients residing in contract homes.

When asked about the adequacy of attention they received, 88.9% (n = 27) felt they received adequate attention. When asked if they perceived any service needs, 62.9% (n = 35) said no, and 22.9% (n = 35) suggested a need for recreational/social activities. These percentages suggest a fairly high level of resident satisfaction. However, on closer examination, the survey methodology employed in the study tends to weaken the findings. To quote from the study:

> In every case where the home operator (or an assistant) was present, he or she was responsible for selecting the respondents from amongst the lodgers. While this ensured that only those capable of answering survey questions were approached and that those without psychiatric histories were eliminated, the selection procedure is likely to have affected the answers of this respondent group. Further, the presence of the operator during the interview may have biased the response to certain questions by their clients. (p.29)

The Task Force concurred with the concern about biased response, but, further, expressed its own concern that, for many psychiatric clients, lack of motivation may be a major problem which has led to placement in a contract home in the first place. Consequently, responses which were non-critical may have reflected this problem of motivation (for example, not motivated to seek employment, complacency regarding financial situation may have resulted, so that there were no perceived needs around personal finances).

Due to these concerns, as well as a desire to let residents speak, Mental Health/Hamilton compiled a list of concerns expressed by residents of lodging homes, group homes et cetera drawn up informally over two days at their Care Centre. Table 2 lists the reported concerns. Of course, this was not a scientific survey and encompassed more than residents from contract lodging homes. It does, however, provide some insight into client "wants".

The interesting trend to note in this list of "wants" is the degree to which small components of what would normally be viewed as independent living are cited. What is strongly suggested is the desire to have more participation. This corresponds to the Task Force's concern about the variable level of client participation in contract homes, and raises the question of the conflict between the client who is referred to a contract home as a step towards independent living (diminishing dependency) and the operator's need to maintain full beds (maintain dependency). This suggests, therefore, that a distinction needs to be made between referrals for the purpose of maintenance and referrals for the purpose of rehabilitation towards independent living, and that the implications of this distinction for operators needs to be articulated.

THE PROBLEM RE-STATED

In summary, the major problems identified by the Task Force in the development of quality of care recommendations were:

1. variability in contract home staffing;
2. variability in programming;
3. variability in levels of client participation;
4. lack of clear criteria for placement;
5. articulation of the goals of specific referrals (maintenance vs rehabilitation)

The second section of this Report will develop a series of recommendations around these issues to begin the process of establishing quality of care arrangements.

TABLE 2

CARE CENTRE SURVEY REGARDING: CLIENT'S OPINIONS RE: LIKES AND WANTS THAT ARE NOT CURRENTLY BEING MET IN LODGING HOMES, HOMES FOR SPECIAL CARE, GROUP HOMES, ETC.

1. Having a recreation, family or T.V. room
2. Smoking allowed in bedrooms
3. T.V. watching with no restrictions on hours
4. Coffee being served on Saturday and in the evening
5. Opportunities to have private discussions with the hostess (that she be more patient)
6. Fresh fruit once a week
7. Private telephone
8. Get paid for doing chores around the house
9. Get to cook food and use kitchen
10. Have access to refrigerator
11. More flexibility in rules
12. More spending money
13. Access to kitchen after 6:00 p.m.
14. Less people with severe behaviour problems in lodging homes
15. Less watered-down coffee and tea
16. More flexible curfew
17. To be able to take more baths
18. Be able to do own laundry
19. Use of house phone occasionally
20. Be able to have female visitors
21. Be able to listen to radio and records

SECTION II

In developing its recommendations, the Task Force first formulated a model of the range of residential facilities in an attempt to firmly situate contract homes along a perceived continuum of alternatives.

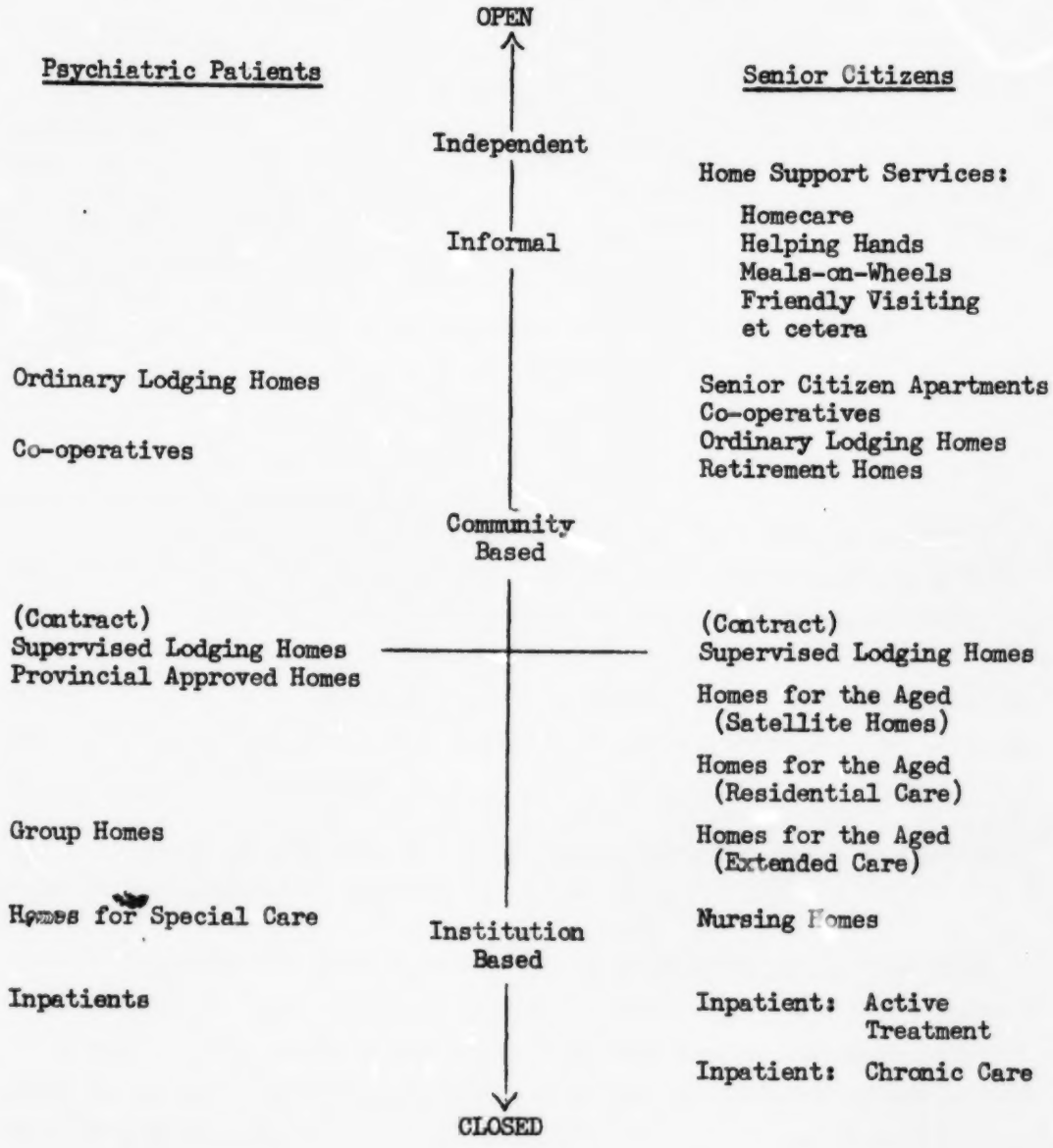
As represented in Figure 2, the Task Force believes that contract homes theoretically occupy a mid-point along a continuum of residential alternatives ranging from open to closed. In particular, contract lodging homes serve residents who require assistance with the activities of daily living, but who are deemed not to require the more intensive supervision structures or nursing care of less "open" points on the continuum. Residents can be functioning at the maintenance, rehabilitation or decline levels. Particular benefits for residents may be derived from the generally smaller resident population of contract homes (less institutional) and their location in established "neighbourhoods". In the opinion of the Task Force, then, contract homes do have a place along the theoretical continuum of care. However, it is also the opinion of the Task Force that, due to the problems stated above in Section I, they are not yet functioning as effectively as they might.

CLIENT-CENTRED PLACEMENT

Believing the needs of the client (as assessed both by clients and professionals) to occupy top priority in a decision to refer, the Task Force developed a theoretical "decision-to-refer" process (see Figure 3 as compared to Figure 2 on page 19).

FIGURE 2

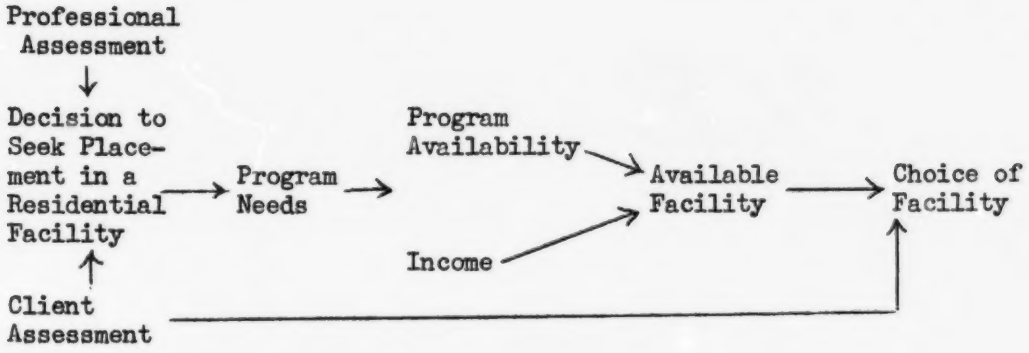
THE CONTINUUM OF CARE APPLIED TO:*



*This Continuum of Care does not suggest that a client move progressively from one point to the next. It is a continuum, instead, applied to the descriptive end points of "open" and "closed".

FIGURE 3

THEORETICAL MODEL OF AN APPROPRIATE REFERRAL PROCESS



Client programme needs and program availability become the major decision points in this model, followed by income constraints and the availability of a facility offering the identified program needs. What is missing from this schema is, however, the growth from the current situation to the ideal expressed in Figure 3. More specifically, we must articulate a mechanism for developing programmes and for matching referrals to these programmes.

Table 3 indicates the client characteristics which should, ideally, be employed in deciding on client needs.

Perhaps the most important of these characteristics are those of diagnosis and prognosis. Minimally, the need for either maintenance or rehabilitation should be key factors in determining what programme might be of most benefit to a client. The current tendency toward custodial care virtually ignores rehabilitation needs, and there is evidence to suggest that, at least in some homes, custodial care - and hence maintenance needs - could be improved.

TABLE 3

CLIENT CHARACTERISTICS WHICH SHOULD BE CONSIDERED FOR ASSESSING NEEDS

Diagnosis
Prognosis (Rehabilitation/Maintenance/Decline)
Age
Sex
Income
Ethnicity
Home Residence

Whether the client needs identified in Table 3 can be met or not depends on the staffing, programmes and level of client involvement which a facility can provide. (We have seen already how variable these factors are in contract homes, and how arbitrary a professional's assessment of a facility might be). It also clearly depends on proper matching between client needs and programme, et cetera, offered. In other words, it depends on appropriate referral.

The Task Force believes that developing a set of criteria for referral is the responsibility of referring agencies. We would see it as most advantageous if such criteria were shared across referring agencies. We recognize, however, that without a forum for the joint development of criteria, globally shared criteria will be difficult to develop. We believe that programme development on a global basis presents the same problem. And, overarching both these problems is the issue of adequate resources to develop both placement mechanisms and the necessary programmes.

The Task Force believes that, where good quality of care is needed and/or expected, it is a fundamental responsibility of government to meet these needs through ensuring the necessary resources.

PROGRAMMES, REFERRAL AND PLACEMENT CRITERIA: RECOMMENDATIONS

Pursuing the original mandate of the Task Force to review the present quality of care arrangements in contract lodging homes has resulted in the conclusion that quality of care is variable and may or may not meet the needs of any given resident.

The key elements in ensuring good quality of care are:

a) appropriate referral/placement;
b) appropriate programmes to meet residents' needs;
c) the allocation of sufficient resources to meet a) and b).

In light of the Task Force's view of contract homes occupying a key position along a continuum of care alternatives, we believe that programme development and referral mechanisms developed together can begin to ensure appropriate quality of care in contract homes. The problem is not a shortage of beds, but, rather, a failure to develop programmes. In other words, existing custodial care can be improved and rehabilitation care introduced.

To this end, the Task Force approves in principle the recommendation of staff to the Metropolitan Toronto Social Services and Housing Sub-committee on Boarding Homes and Lodging Houses contained in the Final Report: Adult Residential Facilities. The recommendation reads:-

> "That the Lieutenant-Governor-in-Council amend the regulations under the Homes for Special Care Act such that additional programs are provided by the Ministry of Health to meet a range of special care needs, and
>
> 1) that such programs range from the highly structured house with 24 hour live-in staff to the modified co-operative which is primarily transitional in nature....

3) that the per diem rates be reviewed and raised to approximate those prescribed for residential care under the Charitable Institutions Act."

This recommendation is derived from the perspective that variable clients' needs require variable programmes and that adequate funding is necessary for this to occur. Further, this recommendation points out the desirability of Provincial involvement in a wide range of adult residential service alternatives, a range to date in which it has only minimally involved itself. We would recommend, therefore:

#2 THAT THE CURRENT PROVINCIAL GOVERNMENT REVIEW OF HOSTELS UNDER THE GENERAL WELFARE ACT SHOULD INCLUDE A COMPREHENSIVE REVIEW OF POLICY, FUNDING AND LEGISLATION. SUCH A REVIEW SHOULD:

i) INCLUDE ONGOING CONSULTATION WITH CONSUMERS (BOTH RESIDENTS, SERVICE PROVIDERS AND AGENCIES REFERRING CLIENTS TO ADULT RESIDENTIAL CARE FACILITIES).

ii) ESTABLISH A LEGISLATIVE FRAME-WORK FOR ENSURING ADEQUATE LICENSING, STAFFING, FUNDING AND PROGRAMMING IN ADULT RESIDENTIAL CARE FACILITIES ACROSS ONTARIO.

iii) INCLUDE THE ESTABLISHMENT OF MECHANISMS WHICH PERMIT A SENSITIVITY TO LOCAL NEEDS AND CONDITIONS IN THE PROVISION OF ADULT RESIDENTIAL CARE SERVICES.

The Task Force feels that the experience of Hamilton is, to a large extent, atypical of municipal responses to the need for licensing, staffing, et cetera guidelines for adult residential care facilities and, in particular, for lodging homes. We feel that this atypicality is a strong argument in favour of provincial initiatives in this area.

However, in developing our own recommendations, we have opted not to invoke provincial legislation as an enabling mechanism. The existence of Hamilton's second level licensing by-law and of the "contract home" gives us a useful enabling mechanism already.

The Task Force is aware of the existence of a number of pieces of legislation which could have some impact on the recommendations which follow. Our major concern, however, has been the development of a feasible process for responding in our own community to the need for clearly articulated levels of care and programming. Clearly, when these recommendations are put into operation, consultation with the various levels of government will be necessary in order to ensure co-ordinated and workable implementation.

The Task Force proposes the concurrent development of a new referral process, programme development in selected contract homes (to be known as Special Programme Homes) and of a new three-way contractual agreement between home operators, the Region and referring agencies. (For further discussion of programmes and operator involvement, please see Appendix 1).

a) SPECIAL PROGRAMME HOMES

The Task Force feels that, given the resources and necessary support and guidelines from referring agencies, that the programmes necessary to meet particular targeted client needs could be provided in selected homes. Contingent on the recommendations which follow, the Task Force recommends that:

#3 i) HOME OPERATORS BE APPROACHED TO DETERMINE THEIR WILLINGNESS TO ALLOW, AND WHERE NECESSARY TO CO-OPERATE WITH AND PARTICIPATE IN THE PROVISION OF SPECIAL PROGRAMMES TO THEIR RESIDENTS, AND THAT HOMES WHICH AGREE TO SUCH AN ARRANGEMENT BE DESIGNATED SPECIAL PROGRAMME HOMES.

ii) THAT SPECIAL PROGRAMME HOME OPERATORS BE REQUIRED TO MEET THE SECOND LEVEL LODGING HOME LICENSE REQUIREMENTS.

iii) THAT THE PROPOSED ADULT RESIDENTIAL CARE FACILITIES COMMITTEE BE RESPONSIBLE FOR IDENTIFYING RESOURCES (INCLUDING FUNDING) NECESSARY FOR THE DEVELOPMENT OF SPECIAL PROGRAMME HOMES.

iv) THAT THE PRIMARY TARGET GROUPS OF SPECIAL PROGRAMME HOMES INITIALLY BE THE ELDERLY AND THE PSYCHIATRIC POPULATION.

v) THAT PROGRAMME DEVELOPMENT BE DETERMINED BY PROGRAMME NEEDS AS ARTICULATED BY THE PROPOSED ADULT RESIDENTIAL CARE FACILITIES COMMITTEE AND AS FURTHER NEGOTIATED WITH SPECIAL PROGRAMME HOME OPERATORS.

b) PROGRAMME DEVELOPMENT AND PLACEMENT CRITERIA

The Task Force, while it explored the nature of the current resident population, had neither the mandate nor expertise to develop programmes to meet the needs of specified key target groups. It has, however, carefully reviewed possible mechanisms for ensuring such a process occurs.

We feel there is a particularly acute responsibility on the part of referring agencies to ensure that client needs are clearly identified and that the necessary programming to meet such needs is clearly articulated. Therefore, we recommend that:

#4 i) AN INDEPENDENT COMMITTEE BE CREATED IN ORDER TO DETERMINE BOTH APPROPRIATE CRITERIA FOR PLACEMENT IN SPECIAL PROGRAMME HOMES AND TO RECOMMEND AND INITIATE THE NECESSARY PROGRAMME DEVELOPMENT TO MEET THE NEEDS OF TARGET CLIENT GROUPS IN SPECIAL PROGRAMME HOMES. THIS COMMITTEE WOULD BE DESIGNATED THE ADULT RESIDENTIAL CARE FACILITIES COMMITTEE AND IT SHOULD INCLUDE REPRESENTATIVES (BOTH ADMINISTRATIVE AND FRONT LINE) FROM:

a) THE PSYCHIATRIC NETWORK;

b) THE SOCIAL WORK DEPARTMENTS OF AREA HOSPITALS;

c) KEY SUPPORT SERVICE PROVIDERS, INCLUDING IN PARTICULAR PUBLIC HEALTH, REPRESENTATIVES FROM VISITING NURSES ORGANIZATIONS, AND HOME CARE;

d) REPRESENTATIVES FROM FAMILY MEDICINE;

e) ASSESSMENT AND PLACEMENT SERVICE;

f) REGIONAL SOCIAL SERVICES AND THE MINISTRIES OF HEALTH AND COMMUNITY AND SOCIAL SERVICES.

ii) THIS COMMITTEE WOULD BE RESPONSIBLE FOR:

a) TARGETING KEY CLIENT GROUPS WHO COULD BENEFIT FROM NEWLY DEVELOPED PROGRAMMES IN SPECIAL PROGRAMME HOMES;

b) SEEKING OUT APPROPRIATE HOME OPERATORS WHO COULD OPERATE SPECIAL PROGRAMME HOMES;

c) DEVELOPING APPROPRIATE SPECIAL PROGRAMMES TO MEET THE NEEDS OF PREVIOUSLY TARGETED CLIENT GROUPS IN CO-OPERATION WITH SELECTED SPECIAL PROGRAMME HOME OPERATORS AND USING EXISTING COMMUNITY RESOURCES WHERE AVAILABLE;

d) DEVELOPING SPECIFIC CRITERIA FOR CLIENT PLACEMENT INTO EACH SPECIAL PROGRAMME HOME AND ITS SPECIAL PROGRAMME;

e) IDENTIFYING RESOURCES (INCLUDING FUNDING) NECESSARY FOR THE DEVELOPMENT OF SPECIAL PROGRAMME HOMES.

It is anticipated by the Task Force that such a committee would be ongoing, and, for that reason, we feel it should be anchored somewhere within the existing network of services. For this reason, we recommend:

#5 THAT, IN ORDER TO ENSURE DEVELOPMENT OF SUCH A COMMITTEE, THE SOCIAL PLANNING AND RESEARCH COUNCIL:

a) DEVELOP A PROJECT PROPOSAL FOR SUCH A COMMITTEE AND SEEK FUNDING FOR A TWO TO THREE YEAR PERIOD FOR A PILOT PROJECT;

b) PROVIDE STAFF SUPPORT TO THE COMMITTEE ON AN INTERIM BASIS UNTIL SUCH TIME AS THE PROPOSAL IS FUNDED;

c) INCLUDE IN THE PILOT PROJECT PROPOSAL:

i) DESCRIPTION OF AN EVALUATION COMPONENT WHICH WOULD INCLUDE PROGRAMME EVALUATION, AND DOCUMENTATION AND EVALUATION OF THE ORGANIZATIONAL AND PROGRAMME PROCESSES WHICH IMPACT ON SPECIAL PROGRAMME HOMES (e.g. THE INTERPLAY OF VARIOUS LEVELS OF GOVERNMENT, FUNDING, PROGRAMME DEVELOPMENT, ETC.)

ii) PLANS FOR POSSIBLE EXPLORATION BY THE COMMITTEE OF FURTHER HOUSING ALTERNATIVES WITHIN THE COMMUNITY ON THE BASIS OF IDENTIFIED PROGRAMME NEEDS.

Further, with the development of programmes and placement criteria, the Task Force recognizes that the referral process will require an administrative framework. We would recommend that:

#6 i) GIVEN PRIOR DEVELOPMENT OF PROGRAMMES AND PLACEMENT CRITERIA BY THE PROPOSED COMMITTEE, THE ASSESSMENT AND PLACEMENT SERVICE OF THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL, AFTER CONSULTATION WITH THE ADULT RESIDENTIAL FACILITIES CARE COMMITTEE, BECOME THE ADMINISTRATIVE AGENCY RESPONSIBLE FOR CO-ORDINATING THE PLACEMENT OF CLIENTS INTO SPECIAL PROGRAMME HOMES.

ii) THE DISTRICT HEALTH COUNCIL ENSURE THAT SUFFICIENT FUNDING IS PROVIDED TO THE ASSESSMENT AND PLACEMENT SERVICE TO INCORPORATE THIS BROADENING OF ITS SERVICES.

c) FOLLOW-UP

An important aspect of ensuring that appropriate placement is made and that the placement is meeting the ongoing needs of the clients is providing for adequate discharge planning and client follow-up. With Special Programme Homes, the Task Force anticipates that discharge planning and follow-up will play an important role in determining the success of a placement. We therefore recommend that:

#7 ALL REFERRING AGENCIES BE STRONGLY URGED TO IMPLEMENT (WHERE THEY CURRENTLY DO NOT HAVE) AND/OR MAINTAIN ACCOUNTABLE FULL DISCHARGE PLANNING AND FOLLOW-UP PROCEDURES TO ENSURE CONTINUITY OF CARE. SUCH PROCEDURES MIGHT INCLUDE INDIVIDUAL WORKERS DEVELOPING THEIR OWN DISCHARGE PLANS OR THE DEVELOPMENT OF A TEAM OF COMMUNITY WORKERS WORKING WITH INDIVIDUAL WORKERS OR A DISCHARGE PLANNER AND ATTACHED EITHER TO THE REFERRING AGENCY OR TO A SERIES OF SPECIAL PROGRAMME HOMES.

d) THE REGION OF HAMILTON-WENTWORTH

Given the variable nature of licensing across the Region, the Task Force would further recommend (in order to ensure that residents in non-licensed facilities elsewhere in the Region receive a good quality of care) that:

#8 THE SOCIAL PLANNING AND RESEARCH COUNCIL STRONGLY URGE AREA MUNICIPALITIES OTHER THAN HAMILTON TO ADOPT BOTH ORDINARY LODGING HOME AND SECOND LEVEL LODGING HOME LICENSING BY-LAWS.

URBAN DOCUMENTATION CENTRE
RESEARCH UNIT FOR URBAN STUDIES
McMASTER UNIVERSITY
HAMILTON, ONTARIO

CONCLUSIONS

In making this rather extensive set of recommendations, the Task Force on Lodging Homes has sought to establish an effective set of mechanisms which will link good quality of care to reasonable financial remuneration to private operators. More important, however, we have attempted to develop a mechanism sensitive to client needs.

The recommendations included in this report are both innovative and client-centred. It is the hope of the Task Force that, in their implementation, they will provide an important first step in the better utilization of community-based adult residential care facilities.

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LIST OF RECOMMENDATIONS

#1 THAT THE SOCIAL PLANNING AND RESEARCH COUNCIL DETERMINE WHETHER OR NOT SUFFICIENT RESOURCES HAVE BEEN ALLOCATED TO ENSURE EFFECTIVE ONGOING ENFORCEMENT OF BY-LAW NO. 80-259 (81-93).

#2 THAT THE CURRENT PROVINCIAL GOVERNMENT REVIEW OF HOSTELS UNDER THE GENERAL WELFARE ACT SHOULD INCLUDE A COMPREHENSIVE REVIEW OF POLICY, FUNDING AND LEGISLATION. SUCH A REVIEW SHOULD:

i) INCLUDE ONGOING CONSULTATION WITH CONSUMERS (BOTH RESIDENTS, SERVICE PROVIDERS, AND AGENCIES REFERRING CLIENTS TO ADULT RESIDENTIAL CARE FACILITIES);

ii) ESTABLISH A LEGISLATIVE FRAMEWORK FOR ENSURING ADEQUATE LICENSING, STAFFING, FUNDING AND PROGRAMMING IN ADULT RESIDENTIAL CARE FACILITIES ACROSS CANADA;

iii) INCLUDE THE ESTABLISHMENT OF MECHANISMS WHICH PERMIT A SENSITIVITY TO LOCAL NEEDS AND CONDITIONS IN THE PROVISION OF ADULT RESIDENTIAL CARE SERVICES.

#3 i) HOME OPERATORS BE APPROACHED TO DETERMINE THEIR WILLINGNESS TO ALLOW, AND WHERE NECESSARY TO CO-OPERATE WITH AND PARTICIPATE IN THE PROVISION OF SPECIAL PROGRAMMES TO THEIR RESIDENTS, AND THAT HOMES WHICH AGREE TO SUCH AN ARRANGEMENT BE DESIGNATED SPECIAL PROGRAMME HOMES;

ii) THAT SPECIAL PROGRAMME HOME OPERATORS BE REQUIRED TO MEET THE SECOND LEVEL LODGING HOME LICENSE REQUIREMENTS;

iii) THAT THE PROPOSED ADULT RESIDENTIAL FACILITIES CARE COMMITTEE BE RESPONSIBLE FOR IDENTIFYING RESOURCES (INCLUDING FUNDING) NECESSARY FOR THE DEVELOPMENT OF SPECIAL PROGRAMME HOMES;

iv) THAT THE PRIMARY TARGET GROUPS OF SPECIAL PROGRAMME HOMES INITIALLY BE THE ELDERLY AND THE PSYCHIATRIC POPULATION.

v) THAT PROGRAMME DEVELOPMENT BE DETERMINED BY PROGRAMME NEEDS AS ARTICULATED BY THE ADULT RESIDENTIAL CARE FACILITIES COMMITTEE AND AS FURTHER NEGOTIATED WITH SPECIAL PROGRAMME HOME OPERATORS

#4 i) AN INDEPENDENT COMMITTEE BE CREATED IN ORDER TO DETERMINE BOTH APPROPRIATE CRITERIA FOR PLACEMENT IN SPECIAL PROGRAMME HOMES AND TO RECOMMEND AND INITIATE THE NECESSARY PROGRAMME DEVELOPMENT TO MEET THE NEEDS OF TARGET CLIENT GROUPS IN SPECIAL PROGRAMME HOMES. THIS COMMITTEE WOULD BE DESIGNATED THE ADULT RESIDENTIAL CARE FACILITIES COMMITTEE AND IT SHOULD INCLUDE REPRESENTATIVES (BOTH ADMINISTRATIVE AND FRONT LINE) FROM:

a) THE PSYCHIATRIC NETWORK;

b) THE SOCIAL WORK DEPARTMENTS OF AREA HOSPITALS;

c) KEY SUPPORT SERVICE PROVIDERS INCLUDING, IN PARTICULAR, PUBLIC HEALTH, VISITING NURSES ORGANIZATIONS, AND HOME CARE;

d) REPRESENTATIVES FROM FAMILY MEDICINE;

e) ASSESSMENT AND PLACEMENT SERVICE;

f) REGIONAL SOCIAL SERVICES AND THE MINISTRIES OF HEALTH AND COMMUNITY AND SOCIAL SERVICES.

ii) THIS COMMITTEE WOULD BE RESPONSIBLE FOR:

a) TARGETING KEY CLIENT GROUPS WHO COULD BENEFIT FROM NEWLY DEVELOPED PROGRAMMES IN SPECIAL PROGRAMME HOMES;

b) SEEKING OUT APPROPRIATE HOME OPERATORS WHO COULD OPERATE SPECIAL PROGRAMME HOMES;

c) DEVELOPING APPROPRIATE SPECIAL PROGRAMMES TO MEET THE NEEDS OF PREVIOUSLY TARGETED CLIENT GROUPS IN CO-OPERATION WITH SELECTED SPECIAL PROGRAMME HOME OPERATORS AND USING EXISTING COMMUNITY RESOURCES WHERE AVAILABLE;

d) DEVELOPING SPECIFIC CRITERIA FOR CLIENT PLACEMENT INTO EACH SPECIAL PROGRAMME HOME AND ITS SPECIAL PROGRAMME;

e) IDENTIFYING THE RESOURCES (INCLUDING FUNDING) NECESSARY FOR THE DEVELOPMENT OF SPECIAL PROGRAMME HOMES.

#5 THAT, IN ORDER TO ENSURE THE DEVELOPMENT OF SUCH A COMMITTEE, THE SOCIAL PLANNING AND RESEARCH COUNCIL:

a) DEVELOP A PROJECT PROPOSAL FOR SUCH A COMMITTEE AND SEEK FUNDING FOR A TWO TO THREE YEAR PERIOD FOR A PILOT;

b) PROVIDE STAFF SUPPORT TO SUCH A COMMITTEE ON AN INTERIM BASIS UNTIL SUCH TIME AS THE PROPOSAL IS FUNDED;

c) INCLUDE IN THE PROJECT PROPOSAL:

i) DESCRIPTION OF AN EVALUATION COMPONENT WHICH WOULD INCLUDE PROGRAMME EVALUATION, AND DOCUMENTATION AND EVALUATION OF THE ORGANIZATIONAL AND PROGRAMME PROCESSES WHICH IMPACT ON SPECIAL PROGRAMME HOMES (e.g. THE INTERPLAY OF VARIOUS LEVELS OF GOVERNMENT, FUNDING, PROGRAMME DEVELOPMENT, ETC.);

ii) PLANS FOR POSSIBLE EXPLORATION BY THE COMMITTEE OF FURTHER HOUSING ALTERNATIVES WITHIN THE COMMUNITY ON THE BASIS OF IDENTIFIED PROGRAMME NEEDS.

#6 i) GIVEN PRIOR DEVELOPMENT OF PROGRAMS AND PLACEMENT CRITERIA BY THE PROPOSED COMMITTEE, THE ASSESSMENT AND PLACEMENT SERVICE OF HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL, AFTER CONSULTATION WITH THE ADULT RESIDENTIAL CARE FACILITIES COMMITTEE, BECOME THE ADMINISTRATIVE AGENCY RESPONSIBLE FOR CO-ORDINATING THE PLACEMENT OF CLIENTS INTO SPECIAL PROGRAMME HOMES.

ii) THE DISTRICT HEALTH COUNCIL ENSURE THAT SUFFICIENT FUNDING IS PROVIDED TO THE ASSESSMENT AND PLACEMENT SERVICE TO INCORPORATE THIS BROADENING OF ITS SERVICES.

#7 ALL REFERRING AGENCIES BE STRONGLY URGED TO IMPLEMENT (WHERE THEY CURRENTLY DO NOT HAVE) AND/OR MAINTAIN ACCOUNTABLE FULL DISCHARGE PLANNING AND FOLLOW-UP PROCEDURES TO ENSURE CONTINUITY OF CARE. SUCH PROCEDURES MIGHT INCLUDE INDIVIDUAL WORKERS DEVELOPING THEIR OWN DISCHARGE PLANS OR THE DEVELOPMENT OF A TEAM OF COMMUNITY WORKERS WORKING WITH INDIVIDUAL WORKERS OR A DISCHARGE PLANNER AND ATTACHED EITHER TO THE REFERRING AGENCY OR TO A SERIES OF SPECIAL PROGRAMME HOMES.

#8 THE SOCIAL PLANNING AND RESEARCH COUNCIL STRONGLY URGE AREA MUNICIPALITIES OTHER THAN HAMILTON TO ADOPT BOTH ORDINARY LODGING HOME AND SECOND LEVEL LODGING HOME LICENSING BY-LAWS.

APPENDIX 1

PROGRAMMES AND OPERATOR INVOLVEMENT

In order to clarify aspects of the recommendations, we have included here some discussion of programmes and operator involvement.

PROGRAMMES

The term "programme" can lead to some confusion i.e. what types of programme? As stated in the body of the Report, while the Task Force was able to identify target client groups, it had neither the expertise nor the mandate to undertake actual programme development. It is our hope that programme development will be undertaken by the proposed Adult Residential Care Facilities.

However, it is possible to outline the general type of programming the Task Force envisages.

Any single resident should have a path for integration into the community mapped out for him/her. Programming in lodging homes would permit the integration between what is happening to any resident out in the community and which he/she is experiencing in the living environment. We are not advocating the creation of mini-institutions characterized by heavy psycho therapy, but comfortable, reasonably home-like environments where a person can learn the skills of and adjust to the demands of independent living (which most of us take for granted) through co-ordinated and planned programming.

The Task Force has stated that it views lodging homes as occupying a key strategic position on a theoretical continuum of care. This position is best described as a transition point from dependent to independent (or from independent to dependent living) depending on the individual client. Programming becomes the mechanism for creating the milieu appropriate to this transition point.'

While there are programmes in the community, the environment of lodging homes tends to mitigate against the principles of these programmes being extended to the residential arena. For example,

while Mental Health/Hamilton's Care Centre provides life skills training, participants in the programme cannot, in many cases, carry this training into the lodging home. Understaffing, lack of follow-up support from professionals, and the complaint by operators/owners of underfunding mitigate against an open environment. Residents may not be allowed to use kitchen facilities, may have regulated bathing hours, et cetera.

This is further complicated by the nature of the residential population itself. The Task Force has spoken at great length about special needs clients, but this is a good opportunity to put descriptive flesh onto the bones of this somewhat "jargony" phrase.

One operator has provided to us a list of some of the things with which her clients need assistance. Included on this list are:

1. finding activities (leisure, recreational) suitable for them;
2. ensuring residents are dressed properly when going out, including personal grooming (hair brushed, socks on, buttons done up);
3. doing all personal laundry;
4. purchasing or assisting to purchase clothing;
5. making appointments (doctor, haircuts, agencies) and in many cases accompanying clients;
6. tracking down clients who get lost;
7. identifying medical problems and ensuring resident gets medical attention;
8. personal grooming (bathing, washing hair, rinsing, brushing teeth, shaving, using deodorant);
9. allocation of spending money.

In addition, this owner/operator cited extra clean-up and ongoing consultation and one-to-one work with residents and professionals as being tremendously time-consuming. At least with regard to this one lodging home, then, the residents are generally finding the tasks of independent living difficult, and require supervision of what many would consider to be the most basic of living tasks.

Given the day-to-day duties faced by many operators, then, it is not surprising to find rules and regulations which limit a resident's ability to begin to function independently. When an operator's time is consumed simply with trying to supervise such basic tasks, there is little time or energy left to encourage or even permit more complex independence-oriented tasks such as cooking meals. The result may often, in fact, be chaos.

The Task Force acknowledges that there are operators who do, still, attempt to provide the opportunity for residents to both acquire and practice the skills of independent living. Without the planned and co-ordinated involvement of referring agencies and existing community programmes, and other resources, many of these attempts have, however, been either frustrated or only partially fulfilled.

This is where planned programming enters the picture. In the estimation of the Task Force, targeted client groups with similar skill needs (in the case of the psychiatric patient) or activation needs (in the case of the elderly) can be met through programming which creates the appropriate milieu for skills learning (or activation). In other words, the Task Force is calling for programmes which address the problems of integration into the community.

OPERATOR INVOLVEMENT

The Task Force would also like to clarify the potential role for lodging home operators/owners implicit in its recommendations.

The recommendation on "special programme homes" reads that operators will "allow, and where necessary co-operate with and participate in" special programmes.

We do not mean to suggest that operators will provide the programmes. Provision of programmes will lie with professionals and community services through the planning efforts of the Adult Residential Care Facilities Committee.

To draw a full picture of operator involvement is difficult until programme development is underway. The Task Force believes that, given the planned and co-ordinated use of and support from community resources, operators' involvement might range from the minimal to more extensive. Where, however, operators must participate in programmes (such as life skills, for example), we would anticipate that this involvement would be conditioned by support and guidance from professionals and staff working in the programme area. For example, it is unrealistic to assume that a life skills programme which would include budgetting for, planning and cooking meals could operate within a home without the operator's participation. Where necessary, training might be required, and, at all times, guidance and back-up from the community, the Committee and professionals must be available.

In contrast, one can as easily imagine programmes where the operator is only minimally involved. For example, for residents to learn about nutrition, might simply require that the operator permit a nutritionist to come into the home to speak to residents.

The important distinction to be made here is, therefore, between provision of and participation in programmes. While operators may vary in their level of participation, provision, planning and co-ordination will come from the community under the planning role of the Adult Residential Care Facilities Committee.